Removal of Actuarial Value requirements for ACA-compliant pediatric standalone dental plans

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In late October 2017, the federal Department of Health and Human Services (HHS) published the draft Notice of Benefit and Payment Parameters for 2019, which sets forth rules related to benefits and exchanges under the Patient Protection and Affordable Care Act (ACA) for the upcoming policy year.

The rule includes a significant change affecting dental benefit plans—namely, removing Actuarial Value (AV) requirements for ACA-compliant standalone pediatric dental plans—which will be critical for dental issuers to understand and act on as the 2019 pricing cycle begins. This article reviews the change and why it is important. With the exception of last year, the final Notice has been released in late February or early March; changes from the draft rule affecting the AV proposal are possible and dental plans should be on alert for this and any other regulatory developments. That being said, as dental issuers start the process of pricing 2019 ACA plans, the removal of AV requirements as detailed in the draft rule should be considered.

For the past several years, ACA-compliant pediatric dental plans sold in the individual or small group market were required to meet standard AV ranges of either 83% to 87% (for "high-level" coverage) or 68% to 72% (for "low-level" coverage). Broadly this meant that the carrier was covering approximately 85% or 70% of total allowed claims, with the remainder funded by the consumer via out-of-pocket expenditures like coinsurance or deductibles. In addition, a $350 limit on out-of-pocket spending ($700 for multiple children under the same policy) was required, limiting the cost outlay for children with high-cost dental needs. For 2019, the AV requirement is dropped; ACA-compliant pediatric standalone dental plans no longer have to meet any particular AV range. There was no change to the out-of-pocket maximum requirement. This change in policy provides new flexibility for dental issuers and closer alignment of pediatric dental benefits between standalone dental plans and pediatric coverage embedded within an ACA medical plan.

The interaction between the two benefit requirements for ACA-compliant standalone pediatric dental plans—maintaining a particular AV and offering an out-of-pocket maximum—caused these plans to look quite different from traditional commercial dental plans and, notably, from pediatric dental coverage embedded in medical plans. For ACA-compliant medical plans that embedded pediatric dental, no separate dental AV was required, nor was a separate dental out-of-pocket maximum, allowing them more flexibility in dental benefit design. A research brief by the American Dental Association's Health Policy Institute compared embedded versus standalone pediatric dental essential health benefits (EHBs), and found that: (1) embedded pediatric dental benefits were more likely to offer first-dollar coverage of preventive dental services, and (2) embedded pediatric dental benefits were less expensive.[1] This was due partly to the required benefit construct of the standalone plan. In order for standalone plans to balance the AV requirements for overall cost sharing while supporting a $350 out-of-pocket maximum, which limits cost sharing for relatively rare high-cost dental issues, instituting consumer cost sharing for common procedures such as preventive care was sometimes the only solution.

With the elimination of standalone pediatric dental AV ranges, dental carriers can develop and market a broader range of standalone pediatric benefit options, allowing for more variety in the balance between preventive benefits and catastrophic cost relief and for closer alignment between standalone and embedded pediatric dental coverage. Carriers that found that requiring member cost sharing on preventive and diagnostic services was the only way to maintain a 70% AV along with a $350 out-of-pocket maximum can now reduce or remove that cost sharing to provide plans that are more desirable to consumers but still less expensive than high AV plans. AVs for those plans will likely be between 72% and 83%. As an example, using the Milliman Health Cost Guidelines™ – Dental pricing model along with illustrative nationwide pricing assumptions, a 2019 ACA-compliant pediatric dental plan with

1 Yarbrough, C., Vujicic, M., & Nasseh, K. (February 2015). More Dental Benefits Options in 2015 Health Insurance Marketplaces. American Dental Association Health Policy Institute Research Brief. Retrieved January 12, 2018, from http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0215_1.ashx.

a $100 deductible on all services, and member coinsurance of 0% for preventive and diagnostic services and 50% for all other services, has an AV of approximately 71%. Changing the plan design so that the deductible is waived for preventive and diagnostic procedures generates an AV of 80%.

Carriers may also develop leaner plans that fall below the AV ranges previously allowed to provide new options with lower premiums to attract price-sensitive consumers. Such plans are likely to have higher member out-of-pocket expenditures even on preventive dental care, but still offer protection against annual outlays above $350. The out-of-pocket maximum provides a de facto floor for AV; if nothing else, an ACA-compliant plan must offer full coverage for the remainder of the policy year once a child incurs $350 in out-of-pocket expenses. Increasing the deductible and/or increasing member coinsurance (the extent to which may be limited by state regulations) will generate lower-premium policies that shift coverage toward protection against catastrophic dental costs as opposed to coverage of routine procedures. This sort of dental coverage is different from traditional plans, which focus on preventive care, but it may be attractive to particular consumer segments.

While the increased flexibility will allow for more variety in plan design, a proliferation of new offerings will likely cause greater confusion for consumers in an environment that is already difficult for consumers to understand. Keeping benefit plans simple and finding ways to communicate plan value to consumers will continue to be critical.

So what is a dental carrier to do? The 2019 ACA filing cycle is upon us and presents a good opportunity for carriers to take stock of current ACA pediatric dental offerings. Which plans have significant membership and which do not? Which ones are profitable? How do your premium levels and cost-sharing requirements stack up against competitors, and how can you use the newfound freedom from AV requirements to craft benefit plans that will offer value to consumers? How can your plans be tweaked to compete against pediatric dental plans embedded in medical coverage? With more variation in the marketplace, adverse selection becomes a larger concern. Strategically resetting benefit plans to attract the desired risk profile will be important to minimize adverse selection effects. Rather than simply continuing to offer the same pediatric plans as in past years, taking some time to make strategic changes in plan design could help to make the products both more desirable and more profitable.

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